

SECTION 10

THE REMITTANCE ADVICE

Missouri Medicaid discontinued printing and mailing paper Remittance Advices (RAs) to most providers effective July 20, 2004. The remittance advices now are available via the Internet through emomed.com. There are two versions available, the 837 format and the Printable RA.

With the implementation of Internet Remittance Advice, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the Division of Medical Services' website, www.dss.mo.gov/dms, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

- 15 – Paper claim
- 18 – Paper Medicare Part B Crossover
- 40 – Electronic Medicare Crossover

- 49 – Internet claim
- 70 – Individual Credit to an Adjustment
- 50 – Individual Adjustment Request
- 75 – Credit Mass Adjustment
- 55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from “001” (January 01) to “365” or “366” in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1504277315020 is read as a paper medical claim entered in the processing system on October 04, 2004.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with [emomed.com](http://www.emomed.com) in order to access the website and the printable RA. To sign-up for [emomed.com](http://www.emomed.com) and the on-line Remittance Advice option, visit the Missouri Medicaid website www.dss.mo.gov/dms and select the Provider Information “internet access” link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser’s instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to <http://www.adobe.com/products/acrobat/readsetp2.html> to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the “Aged RA Request” link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
RECIPIENT NAME	The recipient's last name and first name. NOTE: If the recipient's name and identification number are <u>not</u> on file, only the first two letters of the last name and first letter of the first name appear.
MEDICAID ID	The recipient's 8-digit Medicaid Identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount Medicaid paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient copay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is <u>not</u> present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The Medicaid maximum allowed amount for the procedure.
PAID AMOUNT	The amount Medicaid paid on the claim.

PERF PROV	The Medicaid ID number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	<p>The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes.</p> <p>The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.</p>
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.